County of San Bernardino DBH
Instructions to Complete the MH1950 Cost Report Form
Computation of the Year End Cost Report Settlement

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
PROGRAM SERVICES FY 15/16

Instructions for Completing the Contractor Cost Settlement MH 1950 Report

MH 1950 Summary Settlement worksheet has been simplified and the information is now entered by Modes of Service only. The change was due in fact that most information on this worksheet comes directly from the providers cost report. In additional, the cost report calculates the "Lower of Published Charges or Costs." This form takes into account what the cost report does not. For example, this report considers Maximum Contract Amount, Net County Funds, and County Payment to Providers.

MH 1950 "SCH A BUDGET" COLUMN

Line #		Description
2	Grants Received	Enter Grant Revenues per approved budget schedules.
3	Patient Fees	Enter Patient Fees per approved budget schedules.
4	Patient Insurance	Enter Patient Commercial Insurance per approved budget schedules.
5	Short/Doyle MediCal	Enter total budgeted Medi-Cal cost per approved budget schedules. This includes FFP, EPSDT, 2011 Realignment, and Match funding.
9	Medicare	Enter Medicare Revenue per approved budget scheules.
10	Other Revenues	Enter Other Revenues per approved budget schedules.
11	1991 Realignment	Enter Realignment per approved budget schedules for Non-Medi-Cal services.
12	MHSA	Enter MHSA funding per approved budget schedules for Non-Medi-Cal services.
13	Other Funding	Enter Other Funding per approved budget schedules for Non-Medi-Cal services.

MH 1950 "COST REPORT" COLUMN

Line #		Description
17	1991 Realignment	Enter expenditures attributable to this funding source (up to Line 11 budget amount).
18	MHSA	Enter expenditures attributable to this funding source (up to Line 12 budget amount).
19	Other Funding	Enter expenditures attributable to this funding source (up to Line 13 budget amount).
24	Less: Amount Received from County	Enter the amount received per the contractors' records. Enter a negative number only in this cell.

FY 2015/16 Preliminary Cost Settlement Summary

COUNTY OF SAN BERNARDINO

MH 1950

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This worksheet is intended to be a reference guide when completing your MH 1950 Cost Settlement forms:

Complete the header section of this form and enter data into red shaded cells only.

All other cells are either linked to a cost report form or do not require data entry.

TYPE OF ORGANIZATION:
(CHECK ONE)
_____PROFIT
_____NON-PROFIT

ACCOUNTING METHOD:
(CHECK ONE)
_____CASH
_____ACCRUAL
_____MODIFIED ACCRUAL

		MODE 15		MODE 45		MODE 60		Totals	
		COST REPORT	SCH A BUDGET	COST REPORT	SCH A BUDGET	COST REPORT	SCH A BUDGET	Cost Report /Settlement	Contract #
		MODE 15	MODE 15	MODE 45	MODE 45	MODE 60	MODE 60		0
1	TOTAL EXPENSES/GROSS COST BY MODE, MH1964	$ -		$ -		$ -		$ -	$ -
	CONTRACT PROVIDER REVENUES:							$ -	$ -
2	GRANTS RECEIVED, MH1992, Line 8	$ -		$ -		$ -		$ -	$ -
3	PATIENT FEES, MH1992, Line 9	$ -		$ -		$ -		$ -	$ -
4	PATIENT INSURANCE, MH1992, Line 10	$ -		$ -		$ -		$ -	$ -
5	SD/MC (MEDI-CAL),	$ -						$ -	$ -
6	ENHANCED MEDI-CAL	$ -						$ -	$ -
7	ACA (MEDI-CAL),	$ -						$ -	$ -
8	HEALTHY FAMILIES	$ -						$ -	$ -
9	MEDICARE, MH1992, Line 15	$ -						$ -	$ -
10	OTHER REVENUES, MH1992, Line 17	$ -		$ -		$ -		$ -	$ -
	TOTAL REVENUES RECEIVED	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	SETTLEMENT:								
11	1991 REALIGNMENT							$ -	$ -
12	MHSA							$ -	$ -
13	Other Funding (Non-M/C Agency Match and SB75)							$ -	$ -
14	MAXIMUM CONTRACT AMOUNT per Sch.A		$ -		$ -		$ -	$ -	$ -
15	ACTUAL COST	$ -		$ -		$ -		$ -	
16	MEDI-CAL/ACA/HF/ENHANCED	$ -		$ -		$ -		$ -	
17	1991 Realignment: NEED SUPPORTING DOCUMENTATION							$ -	
18	MHSA: NEED SUPPORTING DOCUMENTATION							$ -	
19	Other Funding (Non-M/C Agency Match and SB75)							$ -	
20	TOTAL FUNDING	$ -		$ -		$ -		$ -	
21	Total Medi-Cal Allowable Cost	$ -		$ -		$ -		$ -	
22	MAXIMUM COST SUBJECT TO REIMBURSEMENT	$ -		$ -		$ -		$ -	
23	Other Adjustments (DBH Use Only)							$ -	
24	LESS: AMOUNT RECEIVED FROM COUNTY (PROVIDER REC.)							$ -	
25	**BALANCE DUE TO: (COUNTY) / PROVIDER**	**$ -**		**$ -**		$ -		**$ -**	**$ -**

Approved by:

DBH Fiscal Preparer (Print Name)	Signature	Date	Provider (Print Name)	Provider Authorized Signature	Date